STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G033	A. BUILDING 00 B. WING	05/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	456 W MARKET ST WABASH, IN 46992

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W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 5/13, 5/14, 5/15, 5/16, 5/20, 5/21, 5/22, and 5/23/2014. Provider Number: 15G033 Facility Number: 000593 AIM Number: 100233370 Surveyor: Susan Eakright, QIDP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed May 30, 2014 by Dotty Walton, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home.	W000104	1. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice: a. new vinyl ordered to repair 10/10 seats on dining room chairs. b. vinyl seats on 10/10 dining chairs will be replaced.2. How will you indentify other residents having the	06/22/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings include: On 5/14/14 from 3:19pm until 5:30pm and on 5/15/14 from 5:40am until 7:45am, observations were conducted at the group home. During both observation periods clients #1, #2, #3, #4, #5, #6, and #7 walked to access the dining room, kitchen, and sat at the dining room table. On 5/14/14 at 4:45pm, ten of ten (10/10) dining room chairs had split vinyl seat cushions covering the ten chair seats. At 4:45pm, Group Home Staff (GHS) #3 indicated the ten chairs needed repair and the split vinyl seat cushions exposed a rough vinyl edges against the buttocks when people sat down on the chairs. On 5/23/14 at 9:30am, an interview with the Community Supports Director (CSD) was conducted. The CSD indicated the group home dining room chairs needed repair and were on the list to be repaired. 9-3-1(a)		potential to be affected by the same deficient practice and what corrective action will be taken: a. 10/10 dining chairs vinyl seats will be replaced. b. Staff will inform Res. Mgr of any cracks in the chairs vinyl seats and put in a maintenance repair request as needed.3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a. 10/10 dining room chairs vinyl seats will be replaced. b. Staff will inform Res. Mgr. of any cracks in the chairs vinyl seats and put in a maintenance repair request as needed.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. a. Staff will inform Res. Mgr. of any cracks in the chairs vinyl seats and put in a maintenance repair request as needed.5. What is the date by which the systematic changes will be completed: a. 6/22/14	
W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as			

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	citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review, and interview, the facility failed to develop criteria for 1 additional client (client #7) to access sharps and utensils. The facility failed to ensure unimpeded access to sharps for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and two additional clients (clients #5 and #6) who did not require restricted access to sharps and utensils. Findings include: On 5/14/14 from 3:19pm until 5:30pm, clients #3, #4, #6, and #7 were observed at the group home and from 4:50pm until 5:30pm clients #1, #2, and #5 were observed at the group home. On 5/14/14 from 3:19pm until 5:30pm, client #7 prepared food in the kitchen with the facility staff. Client #7 opened and closed the drawers to obtain a spoon to stir the food items cooking in pots on the stove. Client #7 cursed verbally at client #4 and called her profane words. At 4:30pm, GHS (Group Home Staff) #2 used a sharp knife he removed from a key lock box on top of the kitchen counter. GHS #2 stated the knives were "locked" because of client #7's "threats" to harm staff and clients inside the group home.	W000125	1. What corrective action(s) will be accomplished for these residents found to be affected by the deficient practice: a. For clients #1-#4 as well as additional clients #5 & #6 in the home a goal will be created in their ISP to ensure they have knowledge of how to Access the Sharps in the home whenever they want for unimpeded access. b. For client #7 a goal will be created in her ISP to educate on the proper use of sharps. c. Staff will be in-serviced on "What sharps are" to ensure that all sharps are locked up for safety of client #7. d. #7 FATS will be updated to include goal for proper sharps use. e. Clients #1, #2, #3 and #4 FATS will be updated to include goal for sharps access.2. How you will identify other residents having the potential to be affectedby the same deficient practice: a. For clients #1-#4 as well as additional clients #5 & #6 in the home a goal will be created in their ISP to ensure they have knowledge of how to Access the Sharps in the home whenever they want for unimpeded access. b. For client #7 a goal will be created in her ISP to educate on the proper use of sharps. c. Any new client (s) moving into the the home will be educated on how to access sharps in the home and have a	06/22/2014

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	GHS #2 stated "all" sharps were to be kept locked. On 5/15/14 from 5:40am until 7:45am, clients #1, #2, #3, #4, #5, #6, and #7 were observed at the group home. During both observation periods inside the kitchen sitting on the counter was a key lock safe with sharp knives, scissors, and sharp objects inside. During both observation periods inside the silverware drawer stored loose inside the drawer were a four inch (4") bladed pizza cutter, a bladed vegetable peeler, and a three and one half inch (3 1/2") bladed knife. On 5/15/14 at 7:00am, GHS #1 stated "all" sharp objects were to have been locked inside the key safe for the "protection" of the clients because of client #7's threats of harm. On 5/23/14 at 9:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated facility staff should have ensured that knives were kept secured and locked after each use. The QIDP indicated the unsecured knife and sharp objects should not have been inside the silverware drawer. The QIDP indicated the practice of locked sharp objects was not addressed in the clients' plans. The QIDP indicated client #7 had a history of misusing sharp objects. The QIDP indicated clients #1, #2, #3, #4, #5, and #6 did not have a identified safety		goal to ensure they know how.3. What measures will be put into place or what systematic changes you will make to ensure that the defienct practices does not recur: a. goal will be created for client #1-#6 To educate how to access sharps. b. In-service all staff on what “sharps” consists of so all sharps are locked up. and to educate clients on access. c. A goal will be created for #1-6 for how to access sharps in home. d. A goal will be created for #7 to be educated on proper uses of sharps. e. All new hires into home will be in-services on the Sharps by Res. Mgr. or QDDP4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. what quality assurance program will be put into place: a. Documentation on #1-7 Sharps goals will be made daily by direct care staff on their goal sheets. b. Res Mgr. will monitor goal sheets to ensure documentation on Sharps goals is bing completed by staff monthly. c. Documentation on Sharps Goals will be review monthly by QDDP.5. What is the date the systimatic changes will be completed: 6/22/14	

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	needs for the locked sharp objects and that sharps were restricted for the clients who lived in the group home. The QIDP indicated the practice of locked sharp objects was not addressed in client #1, #2, #3, #4, #5, and #6's plans. The QIDP indicated clients #1, #2, #3, #4, #5, and #6 would need to gain access to the sharps via staff. On 5/23/14 at 9:23am, client #7's 10/24/13 (Individual Support Plan) and 5/8/14 BSP (Behavior Support Plan) indicated client #7's behaviors included physical aggression, verbal aggression, and non compliance. Client #7's BSP indicated "...To address [Client #7's] threats of harm: 1. Remove or lock up all items that [client #7] could use to harm her self (sic) or others from the group home and day program. [Client #7] has thrown scissors and knives, so plan has focused on these items but not to exclude (sic) other sharp objects. When these items are in use, ensure that staff monitor and secure the items right away. There is a plan in place for locked sharp items as not to infringe (sic) upon the rights of other residents...." Client #7's plans failed to include an objective/goal to teach her responsible methods to utilize locked sharp objects. Client #1's record was reviewed on			

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	5/20/14 at 12:00noon. Client #1's 5/30/13 ISP (Individual Support Plan) and 5/30/13 Functional Assessment Tool (FAT) did not indicate an identified need to lock sharp objects. Client #2's record was reviewed on 5/21/14 at 11:30am. Client #2's 5/22/13 ISP and 5/2014 FAT did not indicate an identified need to lock sharp objects. Client #3's record was reviewed on 5/16/14 at 12:50pm. Client #3's 9/6/13 ISP, 8/6/13 BSP, and 7/29/13 FAT did not indicate an identified need to lock sharp objects. Client #4's record was reviewed on 5/21/14 at 12:15pm. Client #4's 9/19/13 ISP, 8/7/13 BSP, and 8/2013 FAT did not indicate an identified need to lock sharp objects. 9-3-2(a)			
W000242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic			

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	needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Based on observation, record review, and interview, for 1 of 1 sampled clients (client #3) who was non verbal, the facility failed to develop a training program for communication. Findings include: On 5/14/14 from 3:19pm until 5:30pm and on 5/15/14 from 5:40am until 7:45am, client #3 was non verbal. Client #3 stripped her clothing, walked naked inside her bedroom with the door open, paced in the kitchen, and refused the supper meal. From 3:19pm until 5:30pm, client #3 refused verbal requests from staff to not strip her clothing, did not communicate with facility staff, and no system was used to communicate with client #3. From 4:26pm until 4:55pm, GHS (Group Home Staff) #2 spoke to client #3 in a loud tone of voice directly into her face to ask client #3 what she wanted to eat. GHS #1 attempted to sign to client #3 and did not gain eye contact before signing the words food and eat. GHS #3 asked client #3 to show her what client #3 wanted and offered client #3 her hand to hold. At 4:45pm, GHS #1, GHS #2, and GHS #3 indicated client #3 was non verbal and the staff tried different	W000242	1. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice: a. Create a communication goal for client #3. b. Create a PEC Picture Binder to aid in communication with #3 c. Schedule a speech evaluation for #3 d. follow recommendation from Speech eval. e. In-service staff on how to communicate with #3 and on use of her PEC Picture Binder to help with communication. And on getting eye contact with her before signing. f. #3 ISP, FATS & BSP will be updated to include the communication goal and PEC picture binder use as needed. 2. How will you identify other residents having the potenial to be affected by the same deficient practice and what corrective action will be taken: g. Hold IDT meeting to discuss: the stripping incident by #3; review any behavior reports on this behavior; determine what was being communicated by this behavior. a. All new clients moving into the home who are non-verbal will have a communication goal in the ISP. 3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practices does not recur: a. Communication goal added to	06/22/2014

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	ways to communicate with client #3. At 4:45pm, client #3 imitated contact with the surveyor and took the surveyor by the hand to walk then reach upward on the shelf inside the pantry to place the surveyors' hand on a box of macaroni and cheese on the shelf. Client #3's record was reviewed on 5/16/14 at 12:50pm. Client #3's 9/6/13 ISP (Individual Support Plan), 8/6/13 BSP (Behavior Support Plan), and 7/29/13 FAT (Functional Assessment Tool) indicated she was non verbal and did not include how staff were to communicate with client #3. Client #3's plans did not include a training program to teach client #3 to communicate her wants and needs. On 5/23/14 at 9:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #3's plans did not include a training objective to teach client #3 to communicate her wants and needs. The QIDP indicated client #3 did not have a hearing deficit and client #3 had taken staff by the hand to show staff what she desired. 9-3-4(a)		ISP. b. Documentation on goal sheets daily by DSP.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: a. Documentation on goal sheets daily. b. Completion of goal documentation be monitored monthly by Res Mgr. c. Documentation will be reviewed by QDDP monthly.5. Completed by: 6/22/14	

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview, and record review, for 1 additional client (client #7), the facility failed to ensure client #7's BSP (Behavior Support Plan) was implemented to secure knives when opportunities existed. Findings include: On 5/14/14 from 3:19pm until 5:30pm, clients #3, #4, #6, and #7 were observed at the group home and from 4:50pm until 5:30pm clients #1, #2, and #5 were observed at the group home. On 5/14/14 from 3:19pm until 5:30pm, client #7 prepared food in the kitchen with the facility staff. Client #7 opened and closed the drawers to obtain a spoon to stir the food items cooking in pots on the stove. Client #7 cursed verbally at client #4 and called her profane words. At 4:30pm, GHS (Group Home Staff) #2 used a sharp knife he removed from a key lock box on top of the kitchen counter. GHS #2 stated the knives were "locked" because of client #7's "threats" to harm	W000249	1. What corrective action will be accomplished for these residents found to be affected by the deficient practice. a. Staff will be in-serviced on #7 BSP with focus on the need for sharps to be locked up and why. b. Staff will be in-serviced on what all sharps include so that those sharps are secured for safety of clients in the home.2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a. Staff will be in-serviced on #7 BSP with focus on the need for sharps to be locked up and why. b. Staff will be in-serviced on what all sharps include so that those sharps are secured for safety of clients in the home.3. What measures will be put into place or what systemic changes you will make to ensrue that the deficient practices does not recur: a. Staff will be in-serviced and review #7 BSP, on need for sharps locked up. b. All new staff coming to	06/22/2014

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	staff and clients inside the group home. GHS #2 stated "all" sharps were to be kept locked. On 5/15/14 from 5:40am until 7:45am, clients #1, #2, #3, #4, #5, #6, and #7 were observed at the group home. During both observation periods inside the kitchen sitting on the counter was a key lock safe with sharp knives, scissors, and sharp objects inside. During both observation periods inside the silverware drawer stored loose inside the drawer were a four inch (4") bladed pizza cutter, a bladed vegetable peeler, and a three and one half inch (3 1/2") bladed knife. On 5/15/14 at 7:00am, GHS #1 stated "all" sharp objects were to have been locked inside the key safe for the "protection" of the clients because of client #7's threats of harm. On 5/23/14 at 9:23am, client #7's 10/24/13 (Individual Support Plan) and 5/8/14 BSP (Behavior Support Plan) indicated client #7's behaviors included physical aggression, verbal aggression, and non compliance. Client #7's BSP indicated "...To address [Client #7's] threats of harm: 1. Remove or lock up all items that [client #7] could use to harm her self (sic) or others from the group home and day program. [Client #7] has thrown scissors and knives, so plan has focused on these items but not to exclude (sic) other sharp objects. When		work in the home will be trained on #7 BSP and documentation on ABC charts by Res. Mgr. c. Staff will be in-serviced on what all sharps include so that those sharps are secured for safety of clients in the home.4. How will the corrective action be monitored to ensure the deficient practice will not recur, what quality assurance program will be put inot place: a. QDDP will update #7 BSP annually or as needed and given to staff to review.5. What is the date systematic changes will be complete: 6/22/14	

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	these items are in use, ensure that staff monitor and secure the items right away. There is a plan in place for locked sharp items as not to infringe (sic) upon the rights of other residents...." On 5/23/14 at 9:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated facility staff should have ensured that knives were kept secured and locked after each use. The QIDP indicated the unsecured knife and sharp objects should not have been inside the silverware drawer. 9-3-4(a)			